AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

October 06, 2014

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Activity

On September 23, 2014 DPH was awarded $421,842 for the Lead Poisoning Prevention – Childhood Lead Poisoning Prevention Grant. The grant is authorized under ACA §4002.

This project provides funds to assist states in building surveillance capacity to aid in preventing and, ultimately, eliminating childhood lead poisoning. Funded projects will address housing rehabilitation, enforcement of housing and health codes, engagement with health care systems, public and health care provider education campaigns related to lead contamination through other sources, and educational and public health activities.

Massachusetts will use the awarded funds to maintain and enhance their extensive childhood lead poisoning prevention program. This program includes comprehensive case management teams consisting of a nurse case manager, environmental health inspectors and community health workers.

To learn more about the Massachusetts Childhood Lead Poisoning Prevention Program please visit, MASS.GOV

To read the project abstract at MASS.GOV

In September 2014, DPH was awarded $4,168,665 by the Centers for Disease Control and Prevention (CDC) for the State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke grant program, as authorized under ACA §4002.

DPH was awarded $3,520,000 to support the implementation of a population-wide and primary population approach to prevent obesity, diabetes, heart disease and stroke and reduce health disparities among adults. These funds will be used to support a plan that strategically targets the unequal burden of chronic disease borne by the state's most vulnerable residents and communities. DPH was also awarded a supplemental grant of $648,665 to target the same chronic diseases under the State Public Health Action project.

To read the DPH Project abstract please visit, MASS.GOV

On September 19, 2014 The Massachusetts Division of Insurance (DOI) was awarded $1,179,000 through the Grants to States to Support Health Insurance Rate Review and Increase Transparency in the Pricing of Medical Services, Cycle IV, as authorized under ACA §1003.

Awarded funds will help establish a process for the annual review of health insurance premiums in order to protect consumers from unreasonable rate increases. Funds will also be used to establish or enhance rate review programs; to help states provide data to the Secretary of HHS regarding trends in rate increases as well as recommendations regarding participation in the Exchange (ACA §1311); and to establish "Data Centers" that collect, analyze, and disseminate medical pricing data to the public.

Massachusetts DOI plans to use their awarded funds for three projects related to the rate review process. First, conduct a study underlying rate increases by conducting analyses on risk adjustment and reinsurance estimates, provider risk-sharing rearrangements, and cost pressures. Second, conduct follow-up examinations of insurance carriers operating in Massachusetts' merged small group and individual market to confirm that rates generated in 2014 and 2015 were calculated consistent with state and federal rules, and were based on index rates and rating factors as identified in carriers' ratings. Third, to develop a website that will automatically update with rate filing information. The website will present information in a transparent, understandable manner for consumers, including a multi-lingual population.

For more information regarding Massachusetts Rate Review Grant Awards, please visit: CMS.GOV

For information about ACA grants awarded to and grant proposals submitted by the Commonwealth, visit the Grants page of the **Massachusetts National Health Care Reform website** at: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html

Guidance

10/1/14 HHS/CMS issued a correction to the final rule called "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2015." The final rule implements portions of ACA sections 3004, 3401 and 10319. The document makes technical corrections to the final rule (which was published in the Federal Register on August 6, 2014).

The final rule updates the Medicare payment policies and prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2015 (for discharges occurring on or after October 1, 2014 and on or before September 30, 2015). Under the rule, IRF PPS payments for FY 2015 are updated to reflect adjustments as mandated by the ACA. The rule also revises and updates quality measures and reporting requirements under the IRF Quality Reporting Program.

Read the correction at: http://www.gpo.gov/fdsys/pkg/FR-2014-10-01/pdf/2014-23382.pdf

10/1/14 HHS/CMS issued a correcting amendment to a final rule called "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond." The correction fixes technical errors that appeared in the final rule (which was published in the Federal Register on May 27, 2014).

The final rule clarifies key policies applicable to Health Insurance Exchanges and the insurance market reforms under Title I of the ACA relating to: qualified health plan (QHP) quality reporting and enrollee satisfaction surveys; standards for consumer notices related to plan policy coverage changes; modifications in the Small Business Health Options Program (SHOP); standards for Navigators and other consumer assisters and modified premium stabilization policies for 2015 and beyond.

Although HHS has previously outlined many of the major provisions in the rule, the rule further addresses various requirements applicable to health insurance issuers in order to improve consumer protections and stabilize premiums. Under the rule, HHS requires that insurers provide clear information to consumers when they make changes to their policies, such as discontinuing or renewing plans. The rule provides additional guidance to Navigator, non-Navigator and certified application counselors to protect consumers and prohibit assisters from specific solicitation activities.

Building upon the existing QHP certification requirements related to quality reporting and implementation of quality improvement strategies, under the rule HHS requires insurers to submit data to support the calculation of quality ratings which Exchanges will be required to display. Beginning in 2016, Exchanges will be required to present the HHS-calculated quality ratings and enrollee satisfaction survey results in a standardized method designed to help consumers compare and chose health plans.

Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges (Marketplaces) for January 1, 2014 effective dates. The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning in 2014, where low and moderate income Americans may be eligible for premium tax credits (§1401, §1411) to make purchasing a health plan more affordable by reducing out-of-pocket premium costs. §1311(b)(1)(B) also requires that the Small Business Health Options Program (SHOP) assist qualified small employers in facilitating the enrollment of their employees in qualified health programs (QHPs) offered in the small group market. QHPs are health plans that have been certified by an Exchange, provide essential health benefits ("EHB", §1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts).

The ACA established three risk-mitigation programs, which HHS began operationalizing in 2014, to stabilize premiums in the individual insurance market and minimize the effects of adverse selection that may occur as insurance reforms and the Exchanges launch in 2014. These programs include transitional reinsurance (§1341), temporary risk corridors programs (§1342), and a permanent risk adjustment program (§1343) to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers. The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high-cost enrollees. The risk corridors program, which is a federally administered program, will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains.

Read the correction at: http://www.gpo.gov/fdsys/pkg/FR-2014-10-01/pdf/2014-23381.pdf

10/1/14 Treasury/DOL/HHS issued a final rule called "Amendments to Excepted Benefits." The rule amends the agencies' regulations regarding excepted benefits, which are certain types of health-related benefits that that are generally exempt (on a limited or ancillary basis) from the health reform requirements established by the Health Insurance Portability and Accountability Act of 1996, known as HIPPA. HIPAA imposes non-discrimination/portability, privacy and security requirements on group health plans. Benefits that are excepted under HIPAA are not subject to the ACA's market reforms.

The rule expands excepted benefits by identifying certain employee assistance programs (EAPs) as excepted benefits and permitting self-insured plans to cover vision and dental benefits without an extra premium payment. According to the agencies, the final regulations finalize some but not all of the proposed rules with minor modifications and that additional guidance on limited wraparound coverage is forthcoming.

Customarily EAPs are free programs offered by employers that provide an array of benefits to address circumstances that might adversely affect employees' work and health. Benefits may include: short-term substance abuse or mental health counseling or referral services, financial counseling and legal services.

Read the final rule at: http://www.gpo.gov/fdsys/pkg/FR-2014-10-01/pdf/2014-23323.pdf

9/26/14 IRS/Treasury issued a correction and a correcting amendment to final regulations and a correction to temporary regulations called "Branded Prescription Drug Fee." The regulations, which were published in the Federal Register on July 28, 2014, describe the rules related to the fee, including how it is computed and how it is paid. The rules withdraw existing temporary regulations and contain new temporary regulations.

Under ACA §9008, the IRS imposes an annual fee on entities engaged in manufacturing or importing branded prescription drugs. Under the requirement, a non-deductible annual flat fee of $3 billion is imposed on the pharmaceutical manufacturing sector for both 2014 and 2015. In general, the fee is allocated across the industry according to market share and is not applied to companies with sales of branded pharmaceuticals of $5 million or less.

For additional information on the fee, visit the IRS at:
Annual Fee on Branded Prescription Drug Manufacturers and Importers

Read the correction to the final regulations at:
http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-22930.pdf

Read the correcting amendment to the final regulations at:
http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-22929.pdf

Read the correction to the temporary regulations at:
http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-22928.pdf

9/26/14 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on several information collection activities, including the following two collections.

Comments are due October 27, 2014 on all items.

Read the notice at: http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-22980.pdf

> In item #1, HHS/CMS is **seeking comments on a new information collection activity related to Cost Sharing Reduction Reconciliation under the ACA.** According to CMS, the data collection will be used by HHS to make payments or collect charges from health insurance issuers under the following ACA programs: advance payments of the premium tax credit, advanced cost-sharing reductions, and Marketplace (Exchange) user fees. According to CMS, the data collection establishes the data elements that a QHP issuer would be required to report to HHS in order to establish the cost-sharing reductions provided on behalf of enrollees for the benefit year.
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> Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges (Marketplaces) for January 1, 2014 effective dates. The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014. Furthermore, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in a qualified health plan (QHP) through the Exchange and pursue financial assistance (§1401, 1411, and

1412). QHPs are health plans that have been certified by an Exchange, provide essential health benefits (EHB, §1301) and follow established limits on cost-sharing (such as reduced deductibles, copayments, and out-of-pocket maximum amounts).

Using information available at the time of an individual applicant's enrollment, the Exchange determines whether the individual meets income and other requirements for advance payments and the amount of the advance payments that can be used to pay premiums. Advance payments are made periodically to the issuer of the QHP in which the individual enrolls (§1412). §1402 provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange and §1412 provides for the advance payment of these reductions to health insurance issuers. Moreover, the ACA directs the issuers to reduce EHB cost sharing for individuals with household incomes between 100% and 400% FPL who are enrolled in a silver level QHP through an individual market Exchange and who are eligible for advance payments of the premium tax credit.

In item #2, HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to the Medicaid Incentives for Prevention of Chronic Disease (MIPCD) Demonstration.Under section ACA §4108(d)(1), HHS is required to contract with an independent entity or organization to conduct an evaluation of the MIPCD demonstration. Under the demonstration, states receive grants to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs. States must demonstrate changes in health risk and outcomes and address either: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or in the case of a diabetic, improving the management of the condition.

Prior guidance can be found at: http://www.hhs.gov/healthcare/index.html

News

9/30/14 The Patient Centered Outcomes Research Institute (PCORI) approved $102 million in funding in support of a wide range of patient centered clinical effectiveness research projects.

Through the Addressing Disparities program, PCORI will fund two $10 million studies which will focus on obesity treatment options delivered in primary care settings to underserved populations. Through their Improving Healthcare Systems program, PCORI will provide $14.9 million to support a study that will identify which combination of transitional care services will improve outcomes that matter most to patients and their caregivers as they leave the hospital and return to their homes.

PCORI also approved 43 other project awards, totaling $67 million. These projects will compare different options for improving outcomes for conditions such as mental health, cardiovascular disease, diabetes, cancer, and chronic pain among others.

Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies. The PCORI trust fund is funded in part by fees paid by issuers of certain health insurance policies and sponsors of certain self-insured health plans. Since 2012, PCORI has approved $671 million in funding for 360 patient-centered outcomes research projects.

For more information about PCORI, visit PCORI

For more information about these awards and projects, visit PCORI

9/30/14 CMS has made the first wave of pharmaceutical and medical device company payment data available to the public, as authorized by §6002 of the ACA.

This is the first round of Open Payments Data that will be used to help consumers understand the financial relationships between the health care industry, physicians and teaching hospitals. The CMS report contains data from the last five months of 2013 that details information on 4.4 million payments, including $3.5 billion that was paid to 546,000 physicians and almost 1360 teaching hospitals. The report also lists consulting fees,

specifics of research grants, travel reimbursements and other gifts provided throughout the healthcare industry. More than 26,000 physicians and 400 teaching hospitals registered in the Open Payments system to review payments attributed to them.

§6002 requires manufacturers of pharmaceuticals or medical devices to publicly report payments that have been made to physicians and teaching hospitals. These reports create greater transparency around the financial relationships that occur among the healthcare industry. In 2015, this program, known as the Open Payments Program, will provide fully identifiable data after the reporting entity submits corrected data, and physicians and teaching hospitals have a chance to review and dispute the information.

To learn more about the Open Payments Program, please visit CMS.GOV

9/25/14 HHS awarded nearly $212 million in grants to states in order to prevent chronic diseases such as heart disease, stroke and diabetes. Funded in part by the ACA (§4002), the awards will strengthen state and local programs aimed at fighting these chronic diseases, which are the leading causes of death and disability in the United States, and help lower health care costs.

A total of 193 awards were given to states, large and small cities and counties, tribes and tribal organizations, and national and community organizations. Funded programs involve partnerships at the national, state, and/or local levels and aim to achieve three overall goals: reduce prevalence of obesity, lower the rates of death and disability due to diabetes, heart disease, stroke, and reduce the rates of death and disability due to tobacco use.

The Massachusetts DPH was awarded $3,520,000to support the implementation of a population-wide and primary population approach to prevent obesity, diabetes, heart disease and stroke and reduce health disparities among adults. The plan strategically targets the unequal burden of chronic disease borne by the state's most vulnerable residents and communities. DPH was also awarded a supplemental grant of $648,665 to target the same chronic diseases under the State Public Health Action project. For more information on the DPH grant, please see "Grant Activity" above.

Three other organizations in Massachusetts received awards through this opportunity, the Boston Public Health Commission, Old Colony YMCA and Partners in Health. These groups received a combined total of $4,160,985.

To read this announcement and see a list of awardees, visit CDC.GOV

9/24/14 HHS issued a report announcing that the agency is projecting that hospitals will save $5.7 billion in 2014 in uncompensated care costs due to the ACA. According to HHS, spending on uncompensated care is estimated to be 16% less than hospitals' costs would be without the ACA, with states that have expanded Medicaid seeing about 74% of the total savings nationally compared to states that have not expanded Medicaid.

Currently, states make Medicaid Disproportionate Share Hospital (DSH) payments to hospitals that serve a disproportionate share of low income patients and have high levels of uncompensated care costs. The Affordable Care Act expands coverage to millions of Americans. At the same time as the ACA expands coverage that reduces levels of uncompensated care, it also reforms Medicaid DSH allotments to reflect anticipated changes in coverage. ACA §1203 requires aggregate reductions to state Medicaid DSH allotments annually from fiscal year (FY) 2014 through FY 2020. The final rule delineates a methodology to implement the annual reductions for FY 2014 and FY 2015.

With implementation of the ACA, states have opportunities to expand Medicaid coverage to individuals with family incomes at or below 133% of the federal poverty level. This expansion includes non-elderly adults without dependent children, who have not previously been eligible for Medicaid in most states. Twenty-eight states, including the District of Columbia have expanded Medicaid under the Affordable Care Act.

Read the report at: http://aspe.hhs.gov/health/reports/2014/UncompensatedCare/ib_UncompensatedCare.pdf

9/24/14 The U.S. Preventive Services Task Force (USPSTF) issued two final recommendation statements on the prevention of sexually transmitted infections (STIs). The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and adults at increased risk for STIs. In a related recommendation, the USPSTF recommends screening for chlamydia and gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection. The Task Force assigned a "B" rating to both recommendations, indicating that the Task Force recommends the services.

Both final recommendations apply to all sexually active adolescents and adults. The final recommendation on screening for chlamydia and gonorrhea infections also applies to pregnant women. Age is a strong predictor of risk for both chlamydial and gonococcal infections, with the highest infection rates in women age 20 to 24 years.

The USPSTF's evidence review found that STIs are a significant health concern for many Americans. According to CDC estimates, approximately 20 million cases occur each year, with half of those cases in people ages 15 to 24 years. If untreated, STIs such as gonorrhea and chlamydia, can lead to serious complications including pelvic inflammatory disease, complications in pregnancy, chronic pelvic pain, infertility, cancer, and death.

According to the USPSTF, men with chlamydia or gonorrhea infections are more likely than women to experience symptoms for which they would seek medical attention. As a result of earlier detection and treatment, men with these STIs are less likely than women to develop long-term complications. Subsequently, the Task Force concluded that, for men, there is not enough evidence to determine the effectiveness of screening to prevent chlamydia and gonorrhea.

The USPSTF is an independent panel of non-federal government experts that conduct reviews of scientific evidence of preventive health care services. The USPSTF then develops and publishes recommendations for primary care clinicians and health systems in the form of recommendation statements. As part of their recommendations process, the USPSTF will assign definitions to the services they review based on the certainty that a patient will receive a substantial benefit from receiving the benefit. Services that are graded "A" and "B" are highly recommended and the USPSTF believes there is a high certainty that patient will receive a substantial or moderate benefit.

Under ACA §1001, all of the recommended services receiving grades of "A" or "B" must be provided without cost-sharing when delivered by an in-network health insurance provider. Because the recommendations were finalized with "B" ratings, screening for gonorrhea and chlamydia for women and behavioral counseling interventions to prevent sexually transmitted infections must be covered without cost-sharing under the ACA.

Read the final recommendation statement on screening for gonorrhea and chlamydia at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsgono.htm

Read the final recommendation statement on behavioral counseling interventions to prevent sexually transmitted infections at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsstds.htm

Learn more about preventive services covered under the ACA at: HHS.Gov

Learn more about the USPSTF at: http://www.uspreventiveservicestaskforce.org/

Bookmark the **Massachusetts National Health Care Reform website** at: National Health Care Reform to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: Dual Eligibles for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.

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